

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, Film G194 3-27-56 et

2811

## CERTIFICATE OF DEATH

02793

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>				c. LENGTH OF STAY IN 1b <i>9 days.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Menzies Hosp.</i>				d. STREET ADDRESS <i>Mananoy md.</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>ALLAN MONTGOMERY BAILEY</i>				4. DATE OF DEATH Month Day Year <i>MAR 16 1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec 14 1921</i>	
9. AGE (In years last birthday) yrs. <i>74</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farmer.</i>		11. BIRTHPLACE (State or foreign country) <i>wayside md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>James Bailey</i>		14. MOTHER'S MAIDEN NAME <i>Philmaria</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No.</i>	
16. SOCIAL SECURITY NO. <i>583X</i>		17. INFORMANT <i>Frank S Bailey Mananoy md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hemorrhage</i> DUE TO (b) <i>Esophageal varix.</i> DUE TO (c) <i>Hepatic distention</i> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <i>5m</i> <i>12 hrs.</i> <i>3m</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <i>Feb</i> , 19 <i>56</i> , to <i>16 Mar</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>16 March</i> , 19 <i>56</i> , and that death occurred at <i>8:45</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>A. Wooddy</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>La Plata, Md.</i>			
PHYSICIAN'S NAME (Type) <i>ARTHUR O. WOODY</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-18-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mananoy Baptist</i>		22d. LOCATION (City, town, or county) (State) <i>Mananoy md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Grehan Funeral Home Inc La Plata Md</i>				24a. REC'D BY REGISTRAR <i>DATE 3/20/56</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Posey</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

2812

## CERTIFICATE OF DEATH

02794

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>CHARLES</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LA MATA</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>MARYLAND POINT</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Physicians Memorial</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ETHEL PEARL BASTAIN</u>				<b>4. DATE OF DEATH</b> (Month) <u>3</u> (Day) <u>20</u> (Year) <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>2-5-14</u>	9. AGE last birthday <u>42</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>Willie Kidd</u>				14. MOTHER'S MAIDEN NAME <u>MINNE Williamson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>OSCAR BASTAIN - Md. Point</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
171X IMMEDIATE CAUSE (A) <u>Cancer of Cervix, Uterus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Oct 1954</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 54</u> , 19 <u>54</u> , to <u>3-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>3-14</u> , 19 <u>56</u> , and that death occurred at <u>8A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>E. Edelen</u>				DATE SIGNED <u>3-20-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-22-56</u>		NAME OF CEMETERY OR CREMATORY <u>NANJEMOY Baptist</u>		LOCATION (City, town, or county) (State) <u>NANJEMOY, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>3/21/56</u>		REGISTRAR'S SIGNATURE <u>Julia H. Pacey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home</u>		ADDRESS <u>Wardens Ind.</u>	

# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

*ETHEL JEAN BASTAIN*

*F W*

*3 20 15*

*Union of County, Illinois*

*Oct 1914*

*Oct 24 24*

*3-14 25*

*3-14 25*

MAR 23 1956

RECEIVED

REGISTERED

STATE OF NEW YORK DEPARTMENT OF HEALTH-BATON ROUGE, LA

2813

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

02795

Reg. Dist. No. .... 102

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

<b>1. PLACE OF DEATH- COUNTY</b>		<b>MARYLAND</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED- STATE</b>		<b>Maryland</b>		<b>COUNTY</b>		<b>Charles</b>	
<b>CITY</b> (If outside corporate limits, write OR give nearest town)		<b>LENGTH OF STAY</b> (In this place)		<b>CITY</b> (If outside corporate limits, write OR TOWN)		<b>Marshall Hall</b>					
<b>TOWN</b>		<b>82-Yrs</b>		<b>STREET ADDRESS</b>							
<b>HOSPITAL OR STREET ADDRESS</b>				<b>ADDRESS</b>		(If rural, give location)					
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>(First)</b>		<b>(Middle)</b>		<b>(Last)</b>		<b>4. DATE OF DEATH</b>		<b>(Month) (Day) (Year)</b>	
<b>John Richard Bryan</b>								<b>3-8-56</b>		<b>19</b>	
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED,</b> (Specify)		<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b>		<b>If under 1 year Months Days If under 24 hrs. Hours Min.</b>	
<b>Male</b>		<b>W-US</b>		<b>Widowed</b>		<b>3-13-74</b>		<b>81 yrs.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)				<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Farmer</b>				<b>Farmer</b>		<b>Maryland</b>				<b>USA</b>	
<b>13. FATHER'S NAME</b>						<b>14. MOTHER'S MAIDEN NAME</b>					
<b>George R. Bryan</b>						<b>Wilheminna Brown</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT AND ADDRESS</b>					
				<b>None</b>		<b>(Daughter) Frances Grigsby.</b>					
<b>18. MEDICAL CERTIFICATION</b>											
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>										<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.0 Immediate cause (a) Arterio Sclerotic Heart Disease</b>										<b>Indefinite</b>	
<b>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Senility With Arterio Sclerosis</b>										<b>Indefinite</b>	
<b>II. OTHER SIGNIFICANT CONDITIONS</b> Conditions contributing to the death but not related to the disease or condition causing death.										<b>Unknown</b>	
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> <b>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></b>			
<b>21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>				<b>PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY</b>				<b>(CITY OR TOWN) (COUNTY) (STATE)</b>			
<b>TIME (Month) (Day) (Year) (Hour) OF INJURY</b>				<b>INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>				<b>HOW DID INJURY OCCUR?</b>			
<b>22. I certify that I took charge of the remains described above, <del>and conducted</del> Inspection <input checked="" type="checkbox"/>, <del>and conducted</del> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <del>X</del> <del>accident</del> <del>suicide</del> <del>homicide</del> <del>undetermined</del></b>											
<b>SIGNATURE</b>						<b>(Degree or title)</b>			<b>ADDRESS</b>		
<b>James E. Andrews</b>						<b>Indian Head Md.</b>			<b>DATE SIGNED</b>		
									<b>3-11-56</b>		
<b>23. BURIAL, CREMATION REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>		<b>(State)</b>			
<b>Burial</b>		<b>3-13-56</b>		<b>Bumpy Oak Cemetery</b>		<b>Pocomoke Md</b>					
<b>DATE REC'D BY LOCAL REG.</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>24. FUNERAL DIRECTOR</b>		<b>ADDRESS</b>					
<b>3-13-56</b>		<b>J. H. Moore</b>		<b>Hunt Funeral Home</b>		<b>WALDORE Md</b>					

RECEIVED

MAR 15 1956

BUREAU V. S.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02796

## 2814 CERTIFICATE OF DEATH

Item 8, Film 4194 3-27-56 et

Reg. Dist. No. 104

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Charles</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Charles</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Wayside</u>				TOWN <u>Wayside</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>THEODORE</u> (Middle) <u>Loosevelt</u> (Last) <u>BUTLER</u>				(Month) <u>3</u> (Day) <u>13</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>March 12, 1904</u>	<b>9. AGE last birthday</b> <u>51</u> yrs.		<b>IF UNDER 1 YEAR</b> (Month) (Day) (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Charles Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Samuel H. Butler</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Julia Jackson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mary H. Butler Wayside Md</u>			
<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>420.1 IMMEDIATE CAUSE (A)</b> <u>Coronary Occlusion</u>				<u>3-13-56</u>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> <u>Angina Pectoris</u>				<u>1954</u>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>acute</u>, to <u>acute</u>, 19 <u>1956</u>, that I last saw the deceased alive on <u>3-13-56</u> and that death occurred at <u>md</u>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>E. J. Edelen</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Lablato Rd</u>		<b>DATE SIGNED</b> <u>3-14-56</u> (State) <u>md</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>March 14, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. John's</u>		<b>LOCATION (City, town, or county)</b> <u>md</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Mr. Wm J. Jones</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Humm Funeral Home</u>		<b>ADDRESS</b> <u>Wayside Md</u>	
<b>DATE</b> <u>MAR 20 1956</u>							

BUREAU V. S.

MAR 20 1956

1971



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 2815 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02797

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <u>Charles</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAPLATA</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>JAMES</u> First <u>EDWARD</u> Middle <u>DYSON</u> Last				4. DATE OF DEATH Month <u>3</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 9 1920</u>	9. AGE (In years last birthday) <u>36</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HANDY MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shanty's Restau</u>		11. BIRTHPLACE (State or foreign country) <u>BEL ALTON MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>ROBERT DYSON</u>				14. MOTHER'S MAIDEN NAME <u>ANNIE MILLS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>CATHERINE JONES (sister)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3-15-56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u>	Month, Day, Year <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. J. EDELEN</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. J. EDELEN M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-19-56</u>		<u>Sacred Heart</u>		<u>La Plata md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Inc. La Plata</u>				24a. REC'D BY REGISTRAR <u>3/19/56</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Hosen</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on duty is necessary, please execute the certificate, writing the words "standing" in pencil in Item 18. Give Pages 1, 2, and 3 to the full-time director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

JAMES EDWARD JONES  
X  
FEB 1956  
ANNIE JONES (sister)  
JAMES EDWARD JONES  
ANNIE JONES (sister)  
JAMES EDWARD JONES  
ANNIE JONES (sister)

BUREAU V. S.

MAR 21 1956

RECEIVED

*[Handwritten signature]*  
F. J. JONES (11)

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

02798

## 2816 CERTIFICATE OF DEATH

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>CHARLES</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>CHARLES</u>			
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>LA PLATA</u>		<u>19 DAYS</u>		TOWN <u>HUGHESVILLE, MARYLAND</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PHYSICIANS' MEMORIAL HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>ROUTE 5</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) (Type or Print) <u>PHILIP STANLEY HARRISON</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MARCH 26 1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W-US.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MARCH 2, 1878</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BANKER (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WIRT HARRISON</u>				14. MOTHER'S MAIDEN NAME <u>ADDIE M. HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>MRS. NELLIE M. HARRISON</u> <u>HUGHESVILLE, MARYLAND</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
204.1 IMMEDIATE CAUSE (A) <u>ACUTE MYELOGENOUS LEUKEMIA</u>		DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>			
ANTECEDENT CAUSE(S) (B) <u>APLASTIC ANEMIA</u>		DUE TO		<u>16 MONTHS</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>ARTERIO-SCLEROSIS, GENERALIZED</u>		DUE TO		<u>10 YEARS</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>JANUARY, 1942</u> , to <u>MARCH 24, 1956</u> , that I last saw the deceased alive on <u>MARCH 26, 1956</u> , and that death occurred at <u>10:20</u> A.M. from the causes and on the date stated above.							
SIGNATURE <u>John N. Griffin</u> M.D.				ADDRESS (Street, city, town, state) <u>Hughesville Ind.</u>		DATE SIGNED <u>3/27/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>3/29/56</u>	NAME OF CEMETERY OR CREMATORY <u>Old Field</u>		LOCATION (City, town, or county) <u>Berlin Md.</u>		(State)	
24. REC'D BY REGISTRAR <u>3/29/56</u>	REGISTRAR'S SIGNATURE <u>Julia H. Casey</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home</u>		ADDRESS <u>2 Valley Md.</u>			

# STATE CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, MASS.

1. NAME OF DECEASED		2. PLACE OF DEATH	
3. SEX		4. AGE	
5. OCCUPATION		6. CAUSE OF DEATH	
7. DATE OF DEATH		8. TIME OF DEATH	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. MARITAL STATUS		12. EDUCATION	
13. RELIGION		14. SERVICE	
15. SIGNATURE OF DECEASED		16. SIGNATURE OF WITNESSES	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF CORONER	
19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF CLERK	
21. SIGNATURE OF JUDGE		22. SIGNATURE OF SHERIFF	
23. SIGNATURE OF JURY		24. SIGNATURE OF GRAND JURY	
25. SIGNATURE OF COURT		26. SIGNATURE OF JUDGE	
27. SIGNATURE OF CLERK		28. SIGNATURE OF SHERIFF	
29. SIGNATURE OF JURY		30. SIGNATURE OF GRAND JURY	
31. SIGNATURE OF COURT		32. SIGNATURE OF JUDGE	
33. SIGNATURE OF CLERK		34. SIGNATURE OF SHERIFF	
35. SIGNATURE OF JURY		36. SIGNATURE OF GRAND JURY	
37. SIGNATURE OF COURT		38. SIGNATURE OF JUDGE	
39. SIGNATURE OF CLERK		40. SIGNATURE OF SHERIFF	
41. SIGNATURE OF JURY		42. SIGNATURE OF GRAND JURY	
43. SIGNATURE OF COURT		44. SIGNATURE OF JUDGE	
45. SIGNATURE OF CLERK		46. SIGNATURE OF SHERIFF	
47. SIGNATURE OF JURY		48. SIGNATURE OF GRAND JURY	
49. SIGNATURE OF COURT		50. SIGNATURE OF JUDGE	
51. SIGNATURE OF CLERK		52. SIGNATURE OF SHERIFF	
53. SIGNATURE OF JURY		54. SIGNATURE OF GRAND JURY	
55. SIGNATURE OF COURT		56. SIGNATURE OF JUDGE	
57. SIGNATURE OF CLERK		58. SIGNATURE OF SHERIFF	
59. SIGNATURE OF JURY		60. SIGNATURE OF GRAND JURY	
61. SIGNATURE OF COURT		62. SIGNATURE OF JUDGE	
63. SIGNATURE OF CLERK		64. SIGNATURE OF SHERIFF	
65. SIGNATURE OF JURY		66. SIGNATURE OF GRAND JURY	
67. SIGNATURE OF COURT		68. SIGNATURE OF JUDGE	
69. SIGNATURE OF CLERK		70. SIGNATURE OF SHERIFF	
71. SIGNATURE OF JURY		72. SIGNATURE OF GRAND JURY	
73. SIGNATURE OF COURT		74. SIGNATURE OF JUDGE	
75. SIGNATURE OF CLERK		76. SIGNATURE OF SHERIFF	
77. SIGNATURE OF JURY		78. SIGNATURE OF GRAND JURY	
79. SIGNATURE OF COURT		80. SIGNATURE OF JUDGE	
81. SIGNATURE OF CLERK		82. SIGNATURE OF SHERIFF	
83. SIGNATURE OF JURY		84. SIGNATURE OF GRAND JURY	
85. SIGNATURE OF COURT		86. SIGNATURE OF JUDGE	
87. SIGNATURE OF CLERK		88. SIGNATURE OF SHERIFF	
89. SIGNATURE OF JURY		90. SIGNATURE OF GRAND JURY	
91. SIGNATURE OF COURT		92. SIGNATURE OF JUDGE	
93. SIGNATURE OF CLERK		94. SIGNATURE OF SHERIFF	
95. SIGNATURE OF JURY		96. SIGNATURE OF GRAND JURY	
97. SIGNATURE OF COURT		98. SIGNATURE OF JUDGE	
99. SIGNATURE OF CLERK		100. SIGNATURE OF SHERIFF	

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BUREAU V. S.

APR 4 1956

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*James J. [illegible]*

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**1** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# 2817 CERTIFICATE OF DEATH

02799

Reg. Dist. No. 106

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <i>Charles</i>	MARYLAND	STATE <i>Dcd</i>	COUNTY <i>Charles</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>RFD Indian Head</i>	LENGTH OF STAY (in this place) <i>1 1/2 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Indian Head (Rural)</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>3. NAME OF DECEASED</b> (Type or Print) <i>David Alonza Jenkins</i>		<b>4. DATE OF DEATH</b> (Month) <i>March</i> (Day) <i>20</i> (Year) <i>1956</i>	
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED,</b> (Specify) <i>Married</i>	<b>8. DATE OF BIRTH</b> <i>Dec. 5, 1891</i>
<b>9. AGE last birthday</b> <i>64</i> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>U.S. Naval Powder Factory</i>	
<b>11. BIRTHPLACE</b> (State or foreign country) <i>Salisbury, Dcd.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.</i>	
<b>13. FATHER'S NAME</b> <i>David A. Jenkins</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>Mary Louise Durham</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>unk</i> (If Yes, give year or dates of service) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>—</i>	
<b>17. INFORMANT &amp; ADDRESS</b> <i>Mrs David A. Jenkins, RFD Indian Head</i>		<b>18. MEDICAL CERTIFICATION</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>177X IMMEDIATE CAUSE (A)</b> <i>Metastatic Carcinoma Prostate</i>		<i>2 years</i>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>July 1954</i> , <b>to</b> <i>3/20</i> , <b>19</b> <i>56</i> <b>that I last saw the deceased alive on</b> <i>March 14, 1956</i> , <b>and that death occurred at</b> <i>7:45 P.M.</i> , <b>from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <i>Frank G. Person</i> M.D.		<b>ADDRESS</b> (Street, city, town, state) <i>Indian Head, Md.</i>	
<b>DATE SIGNED</b> <i>3-20-56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Burial</i>	<b>DATE THEREOF</b> <i>3-24-56</i>	<b>NAME OF CEMETERY OR CREMATORY</b> <i>PARSONS Cem.</i>	<b>LOCATION (City, town, or county)</b> <i>Salisbury, Md.</i>
<b>24. REC'D BY REGISTRAR</b> <i>Mrs. Gay Price</i>	<b>REGISTRAR'S SIGNATURE</b>	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>The Hunt Funeral Home</i>	<b>ADDRESS</b> <i>W. Anderson, Md.</i>

MAR 23 1956



# NOTICE

NOTICE TO THE PUBLIC: The following information is being furnished to the public for their information. It is requested that you do not disseminate this information to the public. If you have any information regarding this matter, please contact the appropriate authorities.

## STATE CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

1. NAME OF DECEASED: *Charles*

2. SEX: *Male*

3. DATE OF BIRTH: *1871*

4. PLACE OF BIRTH: *Massachusetts*

5. DATE OF DEATH: *Dec 2, 1911*

6. PLACE OF DEATH: *At home*

7. CAUSE OF DEATH: *Heart failure*

8. SIGNATURE OF PHYSICIAN: *[Signature]*

9. SIGNATURE OF REGISTRAR: *[Signature]*

10. NAME OF DECEASED: *Charles*

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MAR 22 1955

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2818

Item 9, Film 196 4-23-56 et

## CERTIFICATE OF DEATH

Reg. No. 028040

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural La Plata</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural La Plata</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>WILLIAM HENRY</u> <u>Mayer</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer Ret</u>		11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Mayer</u>				14. MOTHER'S MAIDEN NAME <u>Lena Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>William H. Mayer Jr. La Plata, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory collapse</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 min.</u> <u>19 hrs.</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug.</u> , 19 <u>50</u> , to <u>March 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>March 27</u> , 19 <u>56</u> , and that death occurred at <u>7:15</u> a.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Arthur O. Wooddy</u> M.D.				ADDRESS (Street, city or town, state) <u>La Plata, Maryland</u>		DATE SIGNED <u>3/27/56</u>	
PHYSICIAN'S NAME (Type) <u>Arthur O. Wooddy, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-29-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>mt Rest</u>		22d. LOCATION (City, town, or county) (State) <u>La Plata Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur O. Wooddy</u>				24a. REC'D BY REGISTRAR <u>3/29/56</u>		24b. REGISTRAR'S SIGNATURE <u>Julia H. Boney</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MAYO AND STATE DEPARTMENT OF HEALTH—BALTIMORE 15

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**MEDICAL CERTIFICATION**

VS. A15ME(5)  
5M 9/55

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON, 1871  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7  
191  
Moria Wilkins  
3  
191  
26

3-19-16  
1916  
Lester Thomas  
Supporter

BUREAU V.

MAR 23 1956

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MAR 23 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2820

## CERTIFICATE OF DEATH

02802

Reg. Dist. No. 100

1. PLACE OF DEATH o. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Plains</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>		d. STREET ADDRESS <b>White Plains</b>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>OFFUTT</b> Last <b>OFFUTT</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>2</b> Year <b>19 56</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/18/1885</b>
9. AGE (In years last birthday) yrs. <b>70</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Art</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>ansa</b>	
13. FATHER'S NAME <b>Jerome Offutt</b>		14. MOTHER'S MAIDEN NAME <b>Annie Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clarence Offutt</b>		Address <b>White Plains</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic lymphoid Leukemia</b> <b>204.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>APRIL</b> , 19 <b>55</b> , to <b>2 MARCH</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1 MARCH</b> , 19 <b>56</b> , and that death occurred at <b>2:20 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>LA PLATA, Md.</b> DATE SIGNED <b>3-2-56</b> ACTUAL SIGNATURE <b>F. M. Johnson</b> M.D. PHYSICIAN'S NAME (Type) <b>F. M. JOHNSON MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-25-56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or county) (State) <b>Barnesville Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Grehart Funeral Home Inc</b> <b>La Plata Md.</b>		24a. REC'D BY REGISTRAR DATE <b>3/5/56</b>	
24b. REGISTRAR'S SIGNATURE <b>Julie Harey</b>			



BUREAU V. S.

MAR 7 1956

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2821 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02803

Reg. Dist. No. 100

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CHARLES</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MALCOLM</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hughesville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>LEO</u> First <u>QUADE</u> Middle Last <b>4. DATE OF DEATH</b> Month <u>3</u> Day <u>27</u> Year <u>1956</u>				<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>W.</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>1921</u> <b>9. AGE</b> (In years) <u>34</u> <sup>Months</sup> <u>3</u> <sup>Days</sup> <u>7</u> <sup>Hours</sup> <u>0</u> <sup>Min.</sup> <u>0</u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Bus Station Attendant</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Attendant</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>Andrew S. Quade</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Norma Russell</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>57-34-784</u>		<b>17. INFORMANT</b> <u>Leo Quade</u> Address <u>Hughesville MD</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured base of skull</u> DUE TO (b) <u>Internal hemorrhage (Pleural)</u> (c) <u>Crushed Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Auto accident</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3-27-56</u> <u>3-27-56</u> <u>3-27-56</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/></b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto which hit telephone pole</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>4:30</u> p. m. <u>3-27</u> <u>1956</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
<b>20f. (City or town)</b> <u>Malcolm Ches</u> <b>(County)</b> <u>MD</u> <b>(State)</b> <u>MD</u>				<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <u>E. J. Edele</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>3-27-56</u>			
<b>EXAMINER'S NAME (Type)</b> <u>E. J. EDELEN M.D.</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>3/30/56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Mary's</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Brownstown MD</u> <b>(State)</b> <u>MD</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>The Hunt Funeral Home</u>				<b>ADDRESS</b> <u>1111 N. 1st St.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>APR 4 1956</u>	
<b>24b. REGISTRAR'S SIGNATURE</b> <u>Julia Posy</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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M/H L 602 M

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Division of death records  
Division of death records

RECEIVED  
APR 4 1956  
E. J. EDELEN (L.)  
Division

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 12, 14 Film 194 3-27-56 et

02804

# CERTIFICATE OF DEATH

Reg. Dist. No. 100

2822

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Tobacco, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Tobacco</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				d. STREET ADDRESS <u>X</u>			
3. NAME OF DECEASED (Type or print) First <u>Jens</u> Middle <u>Rasmussen</u> Last <u>Rasmussen</u>				4. DATE OF DEATH Month <u>March</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>30 Aug. 1861</u>		9. AGE (In years last birthday) <u>94</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Jens Rasmussen</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>LFC Kondrup</u>		Address <u>Port Tobacco, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure (</u> <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis; cardiorenal disease</u> DUE TO (c) <u>Senility.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>15 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3 March</u> , 19 <u>56</u> to <u>10 March</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10 March</u> , 19 <u>56</u> , and that death occurred at <u>7:00 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>La Plata, Maryland</u> <u>13 March, 1956</u>							
ACTUAL SIGNATURE <u>A. O. Wooddy</u> PHYSICIAN'S NAME (Type) <u>Dr. A.O. Wooddy</u>				M.D. <u>La Plata, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shilo m E.</u>		22d. LOCATION (City, town, or county) (State) <u>Shilo md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Grehart Funeral Home Inc La Plata md</u>				24a. REC'D BY REGISTRAR DATE <u>3/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>Julia P. Casey</u>	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. OCCUPATION                  [Faint text]</p>	
<p>7. MARITAL STATUS                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. MEDICAL HISTORY                  [Faint text]</p>		<p>10. DATE OF DEATH                  [Faint text]</p>	
<p>11. PLACE OF DEATH                  [Faint text]</p>		<p>12. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>13. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
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<p>97. SIGNATURE OF JURY                  [Faint text]</p>		<p>98. SIGNATURE OF JURY                  [Faint text]</p>	
<p>99. SIGNATURE OF JURY                  [Faint text]</p>		<p>100. SIGNATURE OF JURY                  [Faint text]</p>	

BUREAU V. 1

MAR 16 1956

RECEIVED

2823

## CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chs Memorial Hosp</i>				d. STREET ADDRESS <i>1</i>			
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>M</i> Last <i>RAWLINGS</i>				4. DATE OF DEATH Month <i>March</i> Day <i>18</i> Year <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14, 1918</i>	9. AGE (In years last birthday) <i>37</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William F. Buford</i>				14. MOTHER'S MAIDEN NAME <i>Martha Montgomery</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Roginald Rawlings</i> Address <i>Hughesville md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c) <i>1 yr.</i>						INTERVAL BETWEEN ONSET AND DEATH <i>30 hrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Acute Strangulated Intestinal obstruction - due to Intussusception</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <i>o. n.</i> <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 18, 1956</i> to <i>March 18, 1956</i> , that I last saw the deceased alive on <i>March 18, 1956</i> , and that death occurred at <i>7:45 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. Parran Jarboe</i> M.D.				DATE SIGNED <i>3-18-56</i>			
PHYSICIAN'S NAME (Type) <i>J. PARRAN JARBOE M.D.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>3/21/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>old fields</i>		22d. LOCATION (City, town, or county) (State) <i>Hughesville md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home</i> ADDRESS <i>Waldorf md</i>				24a. REC'D BY REGISTRAR <i>3/21/56</i>		24b. REGISTRAR'S SIGNATURE <i>Julia H. Posey</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		WHITE		JANUARY 5, 1928		MEMPHIS, TENNESSEE	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. PLACE OF DEATH		11. DATE OF DEATH		12. TIME OF DEATH	
ATTORNEY		HEART DISEASE		NATURAL		HOME		JANUARY 6, 1968		10:15 AM	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF DECEASED		16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF OTHER	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
19. NAME OF FUNERAL HOME		20. ADDRESS OF FUNERAL HOME		21. CITY OF FUNERAL HOME		22. STATE OF FUNERAL HOME		23. ZIP CODE OF FUNERAL HOME		24. PHONE NUMBER OF FUNERAL HOME	
[Name]		[Address]		[City]		[State]		[ZIP]		[Phone]	

BUREAU V. 3

MAR 23 1968

RECEIVED

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF RECORDING AND STATISTICAL PURPOSES ONLY. IT DOES NOT CONSTITUTE A LEGAL DOCUMENT. THE STATE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION PROVIDED HEREON.



## 2824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02807

Reg. Dist. No. 100

Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Faulkner</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>HERBERT JOHN STRICKER</i>		4. DATE OF DEATH Month <i>3</i> Day <i>14</i> Year <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 2, 1892</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Unknown</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	9. AGE (In years last birthday) <i>73</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Mrs. Harold Chandler</i>		Address <i>Faulkner Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension</i> DUE TO (c) <i>?</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3-14-56</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>19</i> a. m. <i>?</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. EDELEN</i> M.D.		DATE SIGNED <i>3-15-56</i>	
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>3/17/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Churchland</i>	22d. LOCATION (City, town, or county) (State) <i>Dayton Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home</i>		24a. REC'D BY REGISTRAR <i>Mr. F. Mills Rose</i>	
ADDRESS <i>Washington</i>		24b. REGISTRAR'S SIGNATURE <i>Mr. F. Mills Rose</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Herbert John Stricker  
3 11 25

3-11-25  
Certificate  
The following

BUREAU V. S.

MAR 20 1956

RECEIVED

FILED  
MAR 20 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please excuse the certificate, writing it and "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MAY 7, 17, 18									
Wife's name: film G197									
5-14-56 1 Charles 2825 Item 2, Film 196 1-20-56 et									
Reg. Dist. No. 03965									
1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2825		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Charles</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Playa</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Marbury</i>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Lloyd</i>		Middle <i>Thomas</i>		Last <i>Thomas</i>		4. DATE OF DEATH Month <i>March</i> Day <i>25</i> Year <i>1956</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb-28</i>		9. AGE (In years last birthday) <i>38</i> yrs.	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Wife: Thelery Thomas</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Marbury Charles Co MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>MD</i>			
13. FATHER'S NAME <i>Frank Thomas</i>				14. MOTHER'S MAIDEN NAME <i>Mimmie Brooks Thomas</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <i>Thelery Thomas, wife</i>		Address <i>Marbury Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Alcoholism</i> <i>3220</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: <i>Natural causes</i> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>William V. Lovitt Jr MD</i>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>March 26 1956</i>			
EXAMINER'S NAME (Type) <i>William V. Lovitt Jr MD</i>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>31</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mont Hope Church</i>		22d. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Montgomery Bros 913 Floridian Ave NW</i>				ADDRESS <i>DE</i>		24a. REC'D BY REGISTRAR <i>APR 17 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mrs. F. Wells Pears</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5852

BUREAU V. S.

APR 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2826

## CERTIFICATE OF DEATH

Reg. Dist. No.

02888

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <b>Virginia</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b <b>10 1/2 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Wheeler</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1956</b>
9. AGE (In years lost birthday) yrs. <b>13</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none - infant</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none - infant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Josephine Quors</b>	
13. FATHER'S NAME <b>Nathan Joe Wheeler</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Quors</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Joe Nathan Wheeler, Tompkinsville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Premature birth - 3 lbs. 11 oz. (7 months)</b> <b>762.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atelectasis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3-12-56</b> <b>3-12-56</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-12-56</b> , 19 <b>3-12-56</b> , 19 <b>3-12-56</b> , that I last saw the deceased alive on <b>3-12-56</b> , 19 <b>3-12-56</b> , and that death occurred at <b>7:35 a.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>3/13/56</b>	
ACTUAL SIGNATURE <b>William J. Kurz</b> M.D.		PHYSICIAN'S NAME (Type) <b>William J. Kurz, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/14/56</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Tompkinsville</b>		22d. LOCATION (City, town, or county) (State) <b>Tompkinsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boonsheller</b>		ADDRESS <b>Tompkinsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>3/14/56</b>		24b. REGISTRAR'S SIGNATURE <b>Julia H. Carey</b>	



BUREAU V. S.

MAR 16 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2827

CERTIFICATE OF DEATH

02803

Reg. Dist. No. 100

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>9 das.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial Hospital</i>		d. STREET ADDRESS <i>Potomac Heights md</i>	
3. NAME OF DECEASED (Type or print) First <i>MARY</i> Middle <i>WILLIAMS</i> Last <i>WILLIAMS</i>		4. DATE OF DEATH Month <i>3</i> Day <i>14</i> Year <i>1956</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-22-1913</i>
9. AGE (In years last birthday) <i>42</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Clarence Clash Potomac Heights md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>332x</i> IMMEDIATE CAUSE (a) <i>CEREBROVASCULAR OCCLUSION</i> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>26x POSITIVE</i> <i>SEROLOGICAL TEST FOR SYPHILIS</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6 Mar 1956</i> , to <i>14 Mar 1956</i> , that I last saw the deceased alive on <i>14 Mar 1956</i> , and that death occurred at <i>7:00 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. M. Plummer</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>LA PLATA, MD 3-14-56</i>	
PHYSICIAN'S NAME (Type) <i>FREDERICK W. JOHNSON MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/19/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Pomonkey</i>		22d. LOCATION (City, town, or county) (State) <i>Pomonkey md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Archert Funeral Home Inc La Plata md</i>		24a. REC'D BY REGISTRAR DATE <i>3/19/56</i>	
24b. REGISTRAR'S SIGNATURE <i>Julia H. Carey</i>			

BUREAU V. S.

MAR 21 1956

RECEIVED